STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155616		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/01/2012		
	PROVIDER OR SUPPLIE ARK NURSING AN	D REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 201 E ELM ST NEW ALBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE
TAG F0000	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
	This visit was for Complaint IN00	for the Investigation of 0107210.	F0000		
	Complaint IN00	0107210 Substantiated,			
		eficiencies related to the			
		cited at F282, F309, 323			
	Survey dates: A	April 30 and May 1, 2012			
	Facility number				
	Provider number				
	AIM number: 2	300120200			
	Survey team: A	Anne Marie Crays RN TC			
	Census bed type	e:			
	SNF/NF: 65				
	Residential: 27				
	Total: 92				
	Census payor ty	ype:			
	Medicare: 13	-			
	Medicaid: 44				
	Other: 35				
	Total: 92				
	Sample: 5				
	These deficienc	eies also reflect state			
		n accordance with 410 IAC			
	16.2.				
	•		•		·

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 05/24/2012 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155616 A. BUILDING B. WING		00	COMPLETED 05/01/2012			
LANDMA		REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 201 E ELM ST NEW ALBANY, IN 47150				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	Quality review of Cathy Emswiller						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7E9U11

Facility ID: 001145

If continuation sheet Page 2 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00			COMPLETED	
		155616	A. BUII B. WIN			05/01/2	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
LANIDAAA		DELIADII ITATIONI		201 E E			
LANDINA	RK NUKSING AND	REHABILITATION		INEVV A	LBANY, IN 47150		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CO			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0282	483.20(k)(3)(ii)						
SS=D		QUALIFIED PERSONS/PER					
	CARE PLAN						
		vided or arranged by the					
		rovided by qualified persons					
		th each resident's written					
	plan of care.		F02	02	5000 05DV1050 DV		05/30/2012
		ation, interview, and	F02	02	F282 SERVICES BY QUALIFIED PERSONS/PER		03/30/2012
	· ·	e facility failed to ensure			CARE PLAN I. Resident B ha	.	
	a resident was tra	ansferred to the commode			had no falls related to transfers	_	
	with 2 assist, fail	ed to apply TED hose,			and is being transferred with 2		
	and failed to adm	ninister Bactrim timely as			assist. TED hose were obtain		
	ordered for a urin	nary tract infection, for 1			and are being applied daily for		
		viewed with plans of care,			Resident B per physician's ord		
		_			Resident B has no s/s UTI. II.	All	
	in a sample of 5.	Resident B			residents requiring 2 person		
					assist and TED hose were		
	Findings include	•			identified. Care plans and C.N assignment sheets will be	I.A.	
					updated to reflect these		
	On 4/30/12 at 10	:10 A.M., during the			individualized needs. All		
	initial tour, the in	nterim Director of			residents were reviewed and		
		indicated Resident B had			those residents with labs		
		Il from her wheelchair.			indicative of UTI are being trea	ated	
	recently mad a ran	ii iioiii iici wiicciciiaii.			per physician's order. III. C.N.	A.	
	0 4/20/10 + 10	20 4 34 11 11 11			assignment sheets, clinical		
		:20 A.M., the interim			records and care plans were	ا	
	•	CNA assignment sheet,			reviewed for transfer needs an TED orders. C.N.A. assignme		
	which included the	he assignment for			sheets and care plans will be	iiit	
	Resident B. The	assignment sheet			updated to reflect each resider	nt's	
	indicated: "Assis	t 2."			current needs for transfer		
					assistance and TED hose		
	On 4/30/12 at 11	:20 A.M., Resident B			placement as applicable. A ne		
		ting in a wheelchair in			lab monitoring system was put		
		C			into place that includes but is r		
		Her right leg was on a			limited to; receipt of lab results		
		left leg was on the			MD notification and new orders All new orders will be reviewed		
		t lower leg appeared			daily during IDT meeting to	1	
	slightly reddened	l and swollen. Neither leg			assure proper follow through.	All I	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED		
		155616	B. WIN	G		05/01/2012		
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
				201 E E				
LANDMARK NURSING AND REHABILITATION				NEW A	LBANY, IN 47150			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	l `	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE			
TAG		LSC IDENTIFYING INFORMATION)		TAG	•	DATE		
	had TED hose of During interview A.M., CNA # 1 it to transfer Resid CNA # 1 wheeled dining room to he proceeded to put resident's waist, stand up. Resider and CNA # 1 sat readjusted the gar resident up, adving grab bar. CNA # down on the comentered the room she needed any he "Yes, she's a little also indicated the "usually red," and have TEDS, but she got the new of Con 4/30/12 at 11 record of Resided Diagnoses included to, Vascular Den and Parkinson's of and on the current indicated, "TED"	on 4/30/12 at 11:30 Indicated she was ready ent B to the commode. Indicated the resident from the er bathroom. CNA # 1 In a gait belt around the and attempted to have her ent B was unable to stand, Inthe resident down, Inti belt, and stood the sing her to hold on to the ent 1 then sat the resident ent and asked CNA # 1 if enelp. CNA # 1 indicated, e shaky today." CNA # 1 e resident's legs were d that the resident "did I haven't seen them since chair." :45 A.M., the clinical ent B was reviewed. ded, but were not limited enentia, Diabetes Mellitus,			nursing staff will be educated transfer requirements and faci expectations and TED hose placement. All licensed nurse will be reeducated on proper physician order follow through IV. The Director of Nursing or designee will conduct unannounced audits of 100% Residents requiring TED hose application, on day shift, daily 2 weeks, weekly for 2 weeks, monthly for 2 months and ther quarterly. The Director of Nursing or designee will condunannounced audits of 10% or Residents requiring 2 person assist with transfers, on day slorevening shift, daily for 2 weekly for 2 weeks, monthly for 2 weekly for 2 weeks, monthly for 2 weekly for 2 weeks, monthly for 2 weekly for 2 weeks, monthly for designe will review all new orders daily identify new antibiotic orders a proper follow through. The Director of Nursing will report QA committee weekly for four weeks, monthly for two month and quarterly thereafter. V. Do of Completion: May 30, 2012	on lity s . of for n uct f hift eks, or 2 he e to and		

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Event ID: 7E9U11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155616	A. BUILDING	00	COMPLETED 05/01/2012
		155616	B. WING		05/01/2012
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE ELM ST	
LANDMA	ARK NURSING AN	D REHABILITATION		LBANY, IN 47150	
(X4) ID	·		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	,	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
TAG		ncluded the following	TAG		DATE
	notations:	letuded the following			
	3/19/12 at 3:00	P.M.: "N.O. [new order]			
	received et [and] noted"			
		rder, dated 3/19/12,			
	-	nin UA [urinalysis]			
	[with] C&S [cu indicated."	lture and sensitivity] if			
	Nurse's Notes c	ontinued:			
	3/20/12 at 5:00	A.M.: "Attempted x 2 - st			
	[straight] cath, 1	refused, stated, No, No"			
		5 A.M.:N.O. to obtain			
	urine per straigh	nt cath tonight"			
	3/24/12 at 3:00	A.M.: "Resident upset,			
		tempting to st cath,			
	-	bathroom]had large			
		nt, had to disregard use of			
	urine specimen.	"			
	A Urinalysis rep	oort, dated 3/27/12, had a			
		, signed by the nurse			
		ich indicated, Bactrim DS			
		10 days for UTI. The			
	to the facility.	it was faxed on 3/27/12			
	3/29/12 at 1:00	P.M.: "Spoke with [nurse			
		orders for tx [treatment]			

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Facility ID: 001145

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURV	EY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155616	B. WIN	IG		05/01/2012	2
NAME OF F	PROVIDER OR SUPPLIEF			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				201 E E			
LANDMA	RK NURSING AND	REHABILITATION		NEW A	LBANY, IN 47150		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	· ·			PREFIX			MPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	1	DATE
		otained" A Physician's					
		9/12, indicated, "Bactrim					
	`	e if indicated) x 10 days					
	r/t UTI."						
	4/4/10 . 5.00 .	16 H B 15 H					
		.M.: "Faxed Bactrim					
	DS over to phare	nacy to dose."					
	4/4/12 -4 12:20 1	D.M., !!Call mana! 1 Co					
		P.M.: "Call received from					
		acist]received and noted					
	for Bactrim SS Take [one] po [by mouth]						
	BID [twice daily	y] x 10 days r/t UTI"					
	The resident's M	ledication Administration					
		, dated March and April					
		the resident did not					
		dose of Bactrim until					
	4/4/12.	dose of Bactrill ultil					
	4/4/12.						
ı	An Interdisciplin	nary Care Plan, initially					
	_	and updated 4/4/12,					
		lem of Skin condition,					
		Location bilat [sic]					
		s" The Approaches					
		2 TED hose during					
		elevate feet in bed."					
	waking installu	j crevate reet in ocu.					
	A Quarterly Nur	rsing Assessment, dated					
		ed, "Edema BLE					
		extremities] TED hose					
	-	ers: 2 person assistFall					
		tTotal Score 15 ["A					
		-					
		ore represents high risk					
	for falls"]."						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155616	B. WIN	G		05/01/2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
				201 E E		
LANDMA	RK NURSING AND	REHABILITATION		NEW AL	LBANY, IN 47150	
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		a Set [MDS] assessment,				
	•	dicated Resident B				
	scored a 3 out of	15 for cognition, with 15				
	indicating no me	mory impairment. The				
	MDS assessment	t indicated the resident				
	required extensiv	ve assist of two+ staff for				
	transfer, and was	totally dependent on				
	two+ staff for toi	leting.				
	An Interdisciplin	ary Care Plan, initially				
	dated 8/15/11 an	d updated 4/12/12,				
		em of "ADL [activities				
	_	elf-Care Deficit AEB [as				
		eeds assistance or is				
		ransferToilet useR/T				
	_	cophrenia, Weakness,				
	Parkinson's dx [c	•				
	_	aded: "Provide only the				
		ance/supervision that is				
	neededWeight	•				
	Cueing/prompting	C.				
	Cuemg/prompun	igas needed				
	On 5/1/12 at 9:24	A.M., during interview				
		DON and Administrator,				
		DON and Administrator, indicated Resident B				
		transferred with 2 assist,				
		was nervous. The				
		o indicated Resident B				
		her TED stockings on,				
	and they were on	at that time.				
		10 P.M., during interview				
	with the interim	DON, she indicated she				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155616		A. BUILDING B. WING			COMPLETED 05/01/2012	
	PROVIDER OR SUPPLIER RK NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 201 E ELM ST NEW ALBANY, IN 47150				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	II PRE Tz		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	was the person who wrote the order for the Bactrim on 3/29/12 and faxed it to the pharmacy, because she found it on the clipboard on 3/29/12 and realized it had not been sent to the pharmacy. The interim DON did not know why it took from 3/29/12 until 4/4/12 for the Bactrim to be started, but indicated it needed to be "renal dosed" and it was "the pharmacy's fault." This federal tag relates to Complaint IN00107210. 3.1-35(g)(2)					

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	OF CORRECTION	IDENTIFICATION NUMBER: 155616	(X2) MULTIPLE CC A. BUILDING B. WING	00	05/01	LETED /2012	
		D REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 201 E ELM ST NEW ALBANY, IN 47150				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	A. BUILDING 00		COMPLE	COMPLETED	
		155616	B. WIN			05/01/2	2012	
NAME OF F	AD OUTDED OR GUIDNI TED			STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF F	PROVIDER OR SUPPLIER	<u>.</u>		201 E E	ELM ST			
	RK NURSING AND	REHABILITATION		NEW A	LBANY, IN 47150			
(X4) ID	`		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
F0309	483.25	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	\longrightarrow	DATE	
SS=D	PROVIDE CARE WELL BEING Each resident me must provide the services to attain practicable physic							
		II-being, in accordance with ive assessment and plan of						
	Based on observa	ation, interview and	F03	09	F309 PROVIDE		05/30/2012	
		e facility failed to ensure			CARE/SERVICES FOR			
		ras having frequent loose			HIGHEST WELL BEING .			
		ntinue to receive the			Resident A no longer resides a			
		softener Colace and			this facility. II. TED hose we			
	_	for 1 of 4 residents			obtained and are being applied daily for Resident B per	ا		
					physician's order. BM monitor	ing		
		quate intake and output;			records were reviewed to iden			
		ure TED hose prescribed			those residents experiencing			
		for leg swelling were in			frequent loose stools. Clinical			
		residents reviewed with			records were reviewed to iden those residents with orders for	,		
	1 -	sample of 5. Resident A,			TED hose. III. The Medication	I		
	Resident B				Administration Records for the	I		
	Findings include	:			residents experiencing frequer loose stools will be reviewed b Director of Nursing or Designe	ee.		
	1. The closed clin	nical record of Resident			The physician for any resident identified as receiving stool			
	A was reviewed	at 4/30/12 at 3:50 P.M.			softeners and/or laxatives while	e		
	Diagnoses includ	led, but were not limited			experiencing frequent loose			
	1	al Status, General			stools will be contacted with			
	Weakness, and H	, , , , , , , , , , , , , , , , , , ,			request to hold stool softeners	i		
	., camiloss, and 1.				and/or laxatives while loose stools continue. An "Acute			
	Physician's order	rs, initially dated 3/3/12			Hydration at Risk" policy was			
	I -	nt April 2012 orders,			drafted and approved by QA			
		*			committee. C.N.A. assignmen			
	· ·	ax 17 GMtake 1 dose			sheets will be updated to reflect	ct		
	1 -	ation," and "Colace 100			TED hose placement as			
	mg Take 1 capsu	le by mouth twice daily			applicable. All nursing staff wi	II		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155616	A. BUILDING B. WING		05/01/2012
		R D REHABILITATION TATEMENT OF DEFICIENCIES	STREET 201 E E	ADDRESS, CITY, STATE, ZIP CODE ELM ST LBANY, IN 47150 PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	BITTE
	dated 3/9/12, inc short-term memore totally dependent transfer and toile assessment indicilimited assistance. The resident's we bowels and blad 148 lbs. Nurse's Notes in notations: 4/12/12 at 6:20 / 99.4 - loose stoon noted. Skin pale monitor." 4/12/12 at 8:30 / stools cont. Call status - awaiting intake noted. Not distress noted." 4/12/12 at 9:00 loorders] rec'd for et [and] repeat Uhas had loose stoont. to monitor.	ta Set [MDS] assessment, dicated Resident A had a cory problem, and was at on two+ staff for et use. The MDS cated the resident required se of one staff for eating. eight was continent of der and her weight was cluded the following A.M.: "T [temperature] als x 4 [with] no vomiting Will continue to A.M.: "T 100.4. Loose out to MD regarding return call Good fluid of s/s [signs or symptoms] P.M.: "N/O's [new C-diff x's 2 - 24 hrs apart J/A C&S. Res. [resident] pols x's 1 this shift Will		be educated on Hydration at F policy and TED hose placeme IV. The Director of Nursing of designee will conduct unannounced audits of 100% Residents requiring TED hose application, on day shift, daily 2 weeks, weekly for 2 weeks, monthly for 2 months and ther quarterly. The Director of Nur or designee will review BM monitoring logs daily to identification residents experiencing freque loose stools and interventions. The Hydration at Risk committe interdepartmental in nature and will meet weekly. The Director of Nursing and Hydra at Risk committee will report to QA committee weekly for four weeks, monthly for two month and quarterly thereafter. V. Date of Completion: May 30, 2012	nt. or of for n sing y nt teee

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155616		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/01/2012
	PROVIDER OR SUPPLIE ARK NURSING ANI	R D REHABILITATION	201 E E	ADDRESS, CITY, STATE, ZIP CODE ELM ST LBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	[complaints] voi shiftIncontine	C&S pending. No c/o ced this nt of B&B [bowels and ftMeals fed per			
	have loose stool practitioner] not [No] N/O's @ th	P.M.: "T 101.8. Conts to sDCNP [nurse ified by phone et fax. is timeP.O. fluids ll cont to observe."			
		A.M.: "Res. has been all evening. T 100.5. ntinue x 2"			
	abedADLs [ac	A.M.: "Resident tivities of daily living] ff. Incont [sic] of			
	[new order] to so to treat & eval ro [Vancomycin Ro C-Diff per famil	P.M.: "Resident lab in n.o. end to [name of hospital] It [related to] VRE esistant Enterococcus] & y request. Resident te poor [not] responsive"			
	Record [MAR], indicated the rest the Miralax dail:	Iedication Administration dated April 2012, ident continued to receive y and Colace twice daily (13, 4/14, and 4/15.			

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If continuation sheet

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155616			JLTIPLE CO LDING G	NSTRUCTION 00	(X3) DATE (COMPL 05/01/	ETED
	PROVIDER OR SUPPLIER	REHABILITATION	_	201 E E	DDDRESS, CITY, STATE, ZIP CODE LM ST LBANY, IN 47150	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	following: 4/11/loose [bowel momedium loose; 4 medium loose; 4 medium loose, E loose, Night shift Day shift, 1 med Incontinent, 0, N 4/14/12: Day shift large loose, Night 4/15/12: Day shift On 5/1/12 at 8:2 with the interimindicated she had previous 2 week administration of laxatives when a stools. 2. On 4/30/12 at was observed sitt the dining room footrest, and her ground. The right slightly reddened had TED hose of On 4/30/12 at 11	April 2012, indicated the 12: Evening shift, 1 large vement], Night shift, 1 /12/12: Day shift, 2 evening shift, 1 large it, 6 large watery; 4/13/12: ium loose, Evening shift, 1 light shift, 2 large loose; ft, 0, Evening shift, 1 lat shift, 3 large loose; ft, 2 small loose. O A.M., during interview Director of Nursing, she inserviced staff in the sergarding holding the f stool softeners and/or resident is having loose 11:20 A.M., Resident B ting in a wheelchair in Her right leg was on a left leg was on the it lower leg appeared if and swollen. Neither leg					
	red," and that the	e resident "did have en't seen them since she					

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Event ID: 7E9U11

Facility ID: 001145

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155616	B. WING		05/01/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R		ELM ST	
LANDMA	ARK NURSING AN	D REHABILITATION		ALBANY, IN 47150	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	got the new cha	ir."			
	On 4/30/12 at 1	1:45 A.M., the clinical			
		ent B was reviewed.			
		ided, but were not limited			
	_	mentia, Diabetes Mellitus,			
	and Parkinson's	disease.			
	Δ Physician's or	rder, initially dated 2/7/12			
	1	•			
		ent April 2012 orders,			
	-	Knee-High stocking on			
	in the morning a	and off at bedtime."			
	An Interdiscipli	nary Care Plan, initially			
		and updated 4/4/12,			
		olem of Skin condition,			
	_	g, Location bilat [sic]			
		es" The Approaches			
		2 TED hose during			
	waking hrs [and	l] elevate feet in bed."			
	A Quarterly Nu	rsing Assessment, dated			
		ed, "Edema BLE			
		extremities] TED hose			
	ordered"	extremities] TED hose			
	ordered				
	On 5/1/12 at 8:2	20 A.M., during interview			
		DON and Administrator,			
		N indicated Resident B			
		her TED stockings on,			
		• ,			
	and they were o	n at that time.			
	This federal tag	relates to Complaint			

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	ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155616			00	COME	E SURVEY PLETED 1/2012			
	PROVIDER OR SUPPLIEI	REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 201 E ELM ST NEW ALBANY, IN 47150						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE			
	IN00107210 3.1-37(a)								
	3.1-37(a)								

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Facility ID: 001145

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155616		A. BUILDI B. WING	ING	NSTRUCTION 00 DDRESS, CITY, STATE, ZIP CODE	(X3) DATE S COMPL 05/01/	ETED	
	PROVIDER OR SUPPLIE	R D REHABILITATION	2	201 E E			
(X4) ID PREFIX TAG	(EACH DEFICIE) REGULATORY O	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PR	ID EFIX ΓAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
F0323 SS=D	The facility muse environment rere hazards as is poreceives adequated assistance deviors. Based on observation of the facility of the assistance of the facility of the facili	PERVISION/DEVICES It ensure that the resident mains as free of accident possible; and each resident ate supervision and ces to prevent accidents. Vation, interview, and the facility failed to ensure a for falls was transferred free of two staff, for 1 of 4 and for falls, in a sample accident B had fall from her wheelchair. D:20 A.M., the interim fa CNA assignment sheet, the assignment sheet	F0323		F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DE CES I. Resident B has had n falls related to transfers and is being transferred with 2 assist II. All residents requiring 2 person assist were identified. Care plans and C.N.A. assignment sheets were updat to reflect these individualized needs. III. C.N.A. assignment sheets and care plans were reviewed for transfer needs. C.N.A. assignment sheets and care plans will be updated to reflect each resident's current needs for transfer assistance. nursing staff will be educated of transfer requirements and facil expectations. IV. The Directo of Nursing or designee will conduct unannounced audits of 10% of Residents requiring 2 person assist with transfers, or day shift orevening shift, daily 2 weeks, weekly for 2 weeks, monthly for 2 months and then quarterly. The Director of Nursing will report to QA committee weekly for four wee monthly for two months and quarterly thereafter. V. Date Completion: May 30, 2012	ted All on lity or for	05/30/2012

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155616			ULTIPLE CO LDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/04/2012
		155616	B. WIN			05/01/2012
NAME OF I	PROVIDER OR SUPPLIE	R		201 E E	ADDRESS, CITY, STATE, ZIP CODE	
LANDMA		O REHABILITATION		NEW AI	LBANY, IN 47150	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	,	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
	stand up. Reside	ent B was unable to stand,				
	and CNA # 1 sa	t the resident down,				
	readjusted the ga	ait belt, and stood the				
	resident up, adv	ising her to hold on to the				
	_ ~	† 1 then sat the resident				
		nmode. CNA # 2 then				
		n and asked CNA # 1 if				
	1	help. CNA # 1 indicated,				
	"Yes, she's a litt	le shaky today."				
	On 4/30/12 at 1	1:45 A.M., the clinical				
	record of Reside	ent B was reviewed.				
	Diagnoses inclu	ded, but were not limited				
	to, Vascular Dei	mentia, Diabetes Mellitus,				
	and Parkinson's	disease.				
	A Quarterly Nu	rsing Assessment, dated				
	· ·	ed, "Transfers: 2 person				
		AssessmentTotal Score				
	_	10 or more represents				
	high risk for fall	s"]."				
		ta Set [MDS] assessment,				
	dated 4/11/12, in	ndicated Resident B				
		f 15 for cognition, with 15				
	_	emory impairment. The				
		nt indicated the resident				
	-	ve assist of two+ staff for				
	•	s totally dependent on				
	two+ staff for to	olleting.				
	An Interdisciplin	nary Care Plan, initially				
		nd updated 4/12/12,				
	indicated a prob	lem of "ADL [activities				

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155616		A. BUI	LDING	00	COMPL 05/01/	ETED	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	30,017	
NAME OF F	PROVIDER OR SUPPLIEF	8		201 E E			
LANDMA	RK NURSING AND	REHABILITATION			LBANY, IN 47150		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		Self-Care Deficit AEB [as		IAG			DATE
		eeds assistance or is					
	• •	ransferToilet useR/T					
	•	zophrenia, Weakness,					
	Parkinson's dx [c	-					
		uded: "Provide only the					
		ance/supervision that is					
	neededWeight	bearing,					
	_	ngas needed"					
		0 A.M., during interview					
		DON and Administrator,					
		I indicated Resident B					
		n transferred with 2 assist,					
	but that CNA # 1	l was nervous.					
		relates to Complaint					
	IN00107210.						
	3.1-45(a)(1)						
	3.1 13(4)(1)						

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OF CORRECTION	IDENTIFICATION NUMBER: 155616	A. BUILDING B. WING	00		LETED 1/2012
PROVIDER OR SUPPLIEF	REHABILITATION	201 E E	ADDRESS, CITY, STATE, ZIP ELM ST LBANY, IN 47150	CODE	
RK NURSING AND SUMMARY S (EACH DEFICIEN				SHOULD BE	(XS) COMPLETION DATE

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Event ID: 7E9U11

Facility ID: 001145

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION 00	(X3) DATE S COMPL	
THILD TETH	or condition	155616		LDING		05/01/	
		100010	B. WIN	_		00/01/	2012
NAME OF F	PROVIDER OR SUPPLIER	-			ADDRESS, CITY, STATE, ZIP CODE		
LANDMA	RK NURSING AND	REHABILITATION			ELM ST LLBANY, IN 47150		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
F0327 SS=G	HYDRATION The facility must	UID TO MAINTAIN provide each resident with ake to maintain proper					
	hydration and health. Based on interview and record review, the F0327						
			27	F327 SUFFICIENT FLUIDS T	0	05/30/2012	
	facility failed to	ensure a resident who	ho		MAINTAIN HYDRATION .		
	was having frequent loose stools received adequate hydration, resulting in				Resident A no longer resides a this facility. II. All residents w		
					reviewed for acute clinical	vere	
	hospitalization for			conditions that would place			
	residents sampled for adequate hydration,				resident at risk for dehydration		
	in a sample of 5.				These conditions include;		
	•				prolonged vomiting or loose stools (3+ in 24 hours), Infection	OLIS	
	Findings include	:			process with elevated temperature that lasts >48 hou		
	1. The closed clinical record of Resident A was reviewed at 4/30/12 at 3:50 P.M. Diagnoses included, but were not limited to, Altered Mental Status, General Weakness, and History of CVA.				acute decline in food or fluid intake that lasts >48 hours. III. An "Acute Hydration at Risk" policy was drafted and approved by QA committee. This policy includes but is not limited to; determination of acute at risk		
	A Nutritional Assessment, dated 7/19/11, indicated: "Weight, 7/18/11 = 146Nutrient NeedsFluid (30 cc's/Kg) = 1980 [cc]."				conditions (prolonged vomiting or loose stools (3+ in 24 hours), Infectious process with elevated temperature that lasts >48 hours, acute decline in food or fluid intake that lasts >48 hours), hydration interventions and		
	and on the currer indicated, "Miral daily for constipa mg Take 1 capsu for constipation."	rs, initially dated 3/3/12 at April 2012 orders, ax 17 GMtake 1 dose ation," and "Colace 100 le by mouth twice daily			monitoring/documentation frequency. Identified residents who were deemed "at acute rifor dehydration will be placed the Acute Hydration at Risk program. All nursing staff will educated on the Acute Hydrat at Risk policy. IV. The Direct of Nursing or designee will rev BM monitoring logs daily to	sk" into be ion tor	
	A Minimuni Dat	a set [wids] assessificiti,			Divi monitoring logs daily to		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLI	
		155616	B. WIN	G		05/01/2	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	KO VIDEK OK SOTTEIEN			201 E E			
LANDMA	RK NURSING AND	REHABILITATION		NEW AI	LBANY, IN 47150		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	·	icated Resident A had a			identify residents experiencing frequent loose stools and		
		ory problem, and was	interventions. The Director of				
		t on two+ staff for			Nursing or designee will review	v	
	transfer and toile				24 hour report sheets daily to		
		ated the resident required			identify residents experiencing		
		e of one staff for eating.			conditions increasing risk for dehydration and interventions.		
	The resident's we	eight was continent of			The Hydration at Risk committ	ee	
	bowels and blade	der and her weight was			be interdepartmental in nature		
	148 lbs.				and will meet weekly. The		
					Director of Nursing and Hydrat		
	Nurse's Notes in	cluded the following			at Risk committee will report to QA committee weekly for four)	
	notations:				weeks, monthly for two months	,	
					and quarterly thereafter. V.		
	4/2/12 at 8:45 A.	.M.: "UA C&S			Date of Completion: May 30,		
	[urinalysis cultui	e and sensitivity] called			2012		
	· ·	eceived [and] noted for					
		ntibiotic] 1 gm daily x 7					
		inary tract infection]"					
	auys for Off [ur	mary tract infection]					
	4/10/12 at 2:20 A	A.M.: "F/U [follow-up]					
		CompleteDenies					
		or pain upon urination.					
		encouraged and taken					
	well. Will contin						
	wen. win contin	ac to monitor.					
	4/12/12 at 6:20 /	A.M.: "T [temperature]					
		ls x 4 [with] no vomiting					
	monitor."	Will continue to					
	monitor.						
	4/12/12 at 0.20	M · "T 100 / L aggs					
		A.M.: "T 100.4. Loose					
		out to MD regarding					
	1	return callGood fluid					
	intake noted. No	s/s [signs or symptoms]					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155616	B. WIN			05/01/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
LANDNAA	DICALLIDOUNG AND	DELIA DIL ITA TIONI		201 E E			
		REHABILITATION		NEW AL	LBANY, IN 47150		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	BEFELECT		DATE
	distress noted."						
		P.M.: "N/O's [new					
	_	C-diff x's 2 - 24 hrs apart					
		/A C&S. Res. [resident]					
	has had loose sto	ools x's 1 this shiftWill					
	cont. to monitor.	"					
	4/13/12 at 8:00 A	A.M.: "T 99.5. Loose					
	stools cont. UA	C&S pending. No c/o					
	[complaints] voi	ced this					
	shiftIncontinen	t of B&B [bowels and					
	bladder] this shif	tMeals fed per					
	staff"						
	4/13/12 at 7:30 F	P.M.: "T 101.8. Conts to					
	have loose stools	sDCNP [nurse					
		fied by phone et fax.					
		is timeP.O. fluids					
	_	I cont to observe."					
		. • • • • • • • • • • • • • • • • • • •					
	4/15/12 at 2:30 A	A.M.: "Res. has been					
		all evening. T 100.5.					
	Loose stools con	_					
	Loose stools con	tilide A 2					
	4/15/12 at 11:00	A M · "Resident					
		tivities of daily living]					
	_	ff. Incont [sic] of					
	b&b99.3."	ii. meont [sic] of					
	00077.3.						
	1/15/12 of 4:20 F	P.M.: "Resident lab in n.o.					
	-	end to [name of hospital]					
		t [related to] VRE					
	[Vancomycin Re	esistant Enterococcus] &					

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155616			CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/01/2012
	PROVIDER OR SUPPLIED	R D REHABILITATION	201 E	ADDRESS, CITY, STATE, ZIP CODE ELM ST ALBANY, IN 47150	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
	1 ^	y request. Resident te poor [not] responsive"			
	Record [MAR], indicated the rest the Miralax dail:	Iedication Administration dated April 2012, ident continued to receive y and Colace twice daily /13, 4/14, and 4/15.			
	document, dated following: 4/11/loose [bowel momedium loose; 4 medium loose, Floose, Night shift Day shift, 1 med Incontinent, 0, N 4/14/12: Day shift large loose, Night large large loose, Night large loose, Night large loose, Night large la	BM Monitoring" April 2012, indicated the 12: Evening shift, 1 large overment], Night shift, 1 la/12/12: Day shift, 2 Evening shift, 1 large ft, 6 large watery; 4/13/12: lium loose, Evening shift, light shift, 2 large loose; lift, 0, Evening shift, 1 lat shift, 3 large loose; lift, 2 small loose.			
	Record," dated A resident had the intake: 4/11/12,	Food/Fluid Consumption April 2012, indicated the following 24 hour fluid 360 cc, 4/12/12, 660 cc, 4/14/12, 120 cc, 4/15			
	4/16/12, indicate admission: Clos	ry and physical, dated ed, "Reason for tridium difficile, istant Enterococcus in the			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155616			LDING	NSTRUCTION 00	(X3) DATE COMPI 05/01	LETED	
	PROVIDER OR SUPPLIER	REHABILITATION	p. wiiv	STREET A	LM ST LBANY, IN 47150		
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	urine, dehydratic illness:was sen last night becaus urinewas found insufficiencyLa Studies:Admitti 1-24] and Creatin .6-1.5]" 2. On 5/1/12 at 1 Administrator pr facility "Hydratic April 2012. The assure each resid fluids to prevent the resident's corpossibleEach roof care in place t factors for dehyd Dietician shall ca annually and wit in condition each fluid needs. 4. A 'Hydration at Ris conditions: a. Proloose stools (3+ Infectious procest temperature that decline in fluid in hours5. Hydrat shall have the folloose	onHistory of present to the emergency room the of VRE in the tho be in acute renal aboratory and Imaging ting BUN was 97 [normal mine 2.3 [normal O:10 A.M., the towided the current ton at Risk Policy," dated policy included: "To tent receives adequate dehydration to the extent addition makes this tesident shall have a plan to address identified risk tration. 3. The Registered alculate upon admission, the any significant change to resident's estimated resident shall be deemed the under the following tolonged vomiting and/or tepisodes in 24 hours) b. The session of the extent to the track that lasts >48 The provided the current of the extent to the extent that the following of the extent that the					

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	OF CORRECTION IDENTIFICATION NUMBER: 155616	(X2) MULTIPLE CC A. BUILDING B. WING	00	— COMP 05/01	ESURVEY LETED 1/2012		
LANDMA	PROVIDER OR SUPPLIER ARK NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 201 E ELM ST NEW ALBANY, IN 47150					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	interview with the Administrator, she indicated this policy had been implemented in the previous 2 weeks, and prior to that, there wasn't a hydration policy in writing. The Administrator also indicated hydration had been recently addressed in the facility's quality assurance program. This federal tag relates to Complaint IN00107210 3.1-46(b)						

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	F OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: 155616	A. BUILDING	00 	CO	MPLETED 01/2012
	ROVIDER OR SUPPLIE		201 E E	ADDRESS, CITY, STATE, ZIP C ELM ST LBANY, IN 47150		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE // DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE

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Event ID: 7E9U11

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